ASAM American Society of Addiction Medicine

Using AMNet to Track Opioid Use Disorder Treatment Outcomes

SCHEDULE

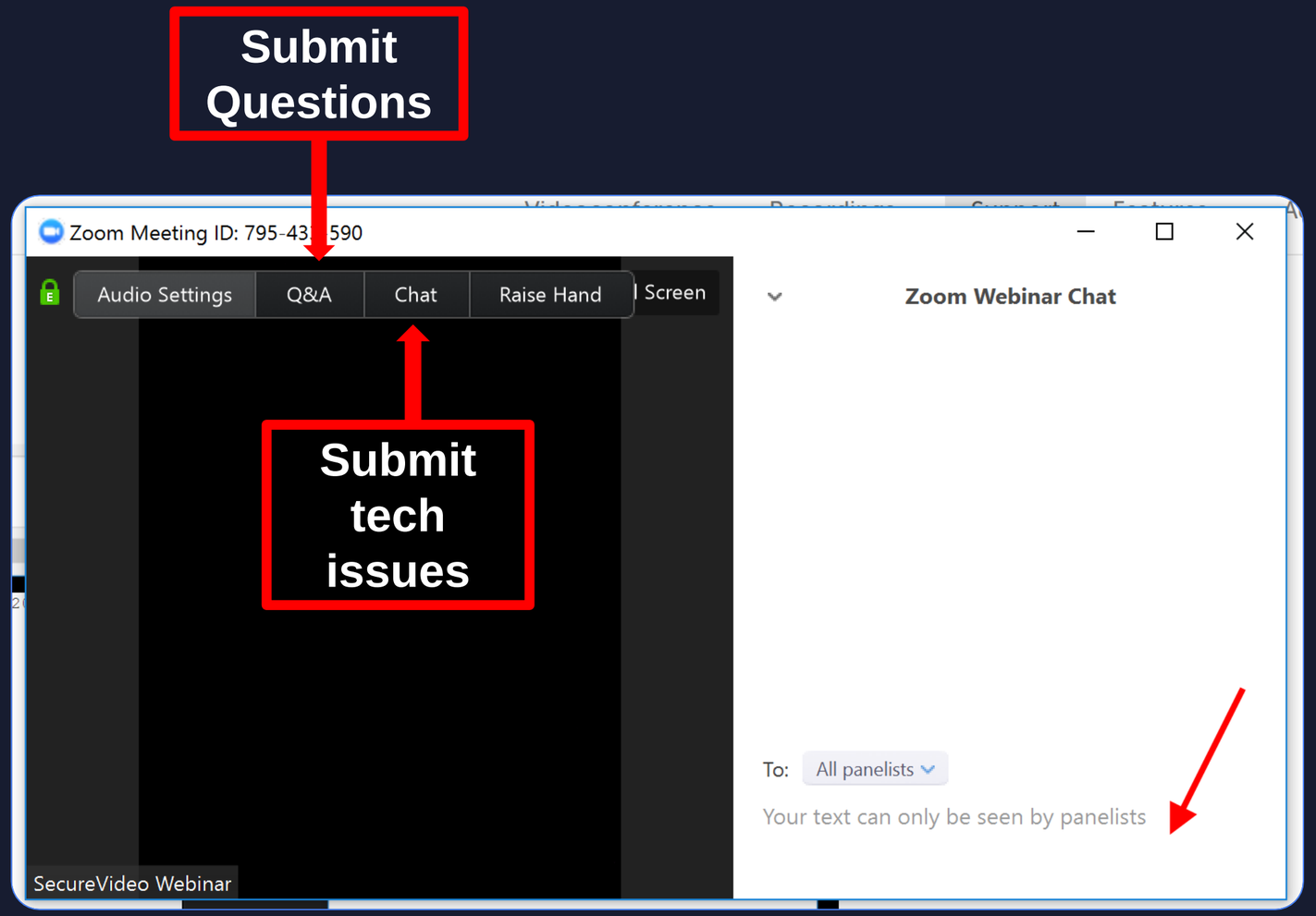
4:00 – 4:05 pm	Announcements ASAM STAFF
4:05 – 4:45 pm	Using AMNet to Track OUD Treatment Outcomes DR. KAMPMAN / DR. HURLEY
4:45 – 5:00 pm	Questions & Answers DR. KAMPMAN / DR. HURLEY
5:00 pm	Concluding Remarks ASAM STAFF

ANNOUNCEMENTS

1. Attendee Audio: Your mics are automatically set to mute.

2. Questions? Type questions into the Q&A box.

3. Technical Issues? Use the chat box feature to submit questions to your hosts.



Using AMNet to Track Opioid Use Disorder Treatment Outcomes

REGISTER (FREE!)

★★★★½ 4.67 (3 votes)

Includes a Live Event on 01/27/2021 at 4:00 PM (EST)

Overview | Speakers | Handouts | Credits and Disclosures | Contents (4)

Using AMNet to Track Opioid Use Disorder Treatment Outcomes

Opioid use disorder is a chronic, relapsing disease, which has significant economic, personal, and public health consequences. The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use was developed to assist in the evaluation and treatment of opioid use disorder. Topics covered included: opioid withdrawal management, psychosocial treatment, special populations, and opioid overdose.

This webinar outlines the highlights of the **2020 Focused Update of the National Practice Guideline for the Treatment of Opioid Use Disorder**, focusing on the several new buprenorphine formulations recently approved by the FDA. The webinar also outlines AMNet measures that can be used to track implementation of the guidelines and treatment outcomes.

AMNET is an Addiction Medicine practice-based research network. Learn more and join the network **here**.

Session Information

Date: Wednesday, January 27, 2021

Time: 4:00-5:00 pm ET

HOW TO OBTAIN CME

1. Go to:

   https://elearning.asam.org/p/NPG2020

2. Go to *Contents* tab

3. Complete:

   - ❑ CME Quiz
   - ❑ Evaluation
   - ❑ Credit and Certificate

PRESENTER

Kyle Kampman, MD, FASAM

- Professor of Psychiatry at the University of Pennsylvania with extensive experience in the treatment of alcohol, cocaine, and opioid dependence.
- Chaired the committee that wrote the *ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use;* a recognized authority on cocaine withdrawal syndrome.
- Works at the Addiction Recovery Unit of the Philadelphia VA Medical treating cocaine, alcohol, and opioid dependent patients with both medications and psychotherapy.

FINANCIAL DISCLOSURES – Dr. Kampman

- Alkermes, Other Research Support (includes receipt of drugs, supplies, equipment or other in-kind support), Clinical Condition: Opioid Use Disorder

- World meds, Other Research Support (includes receipt of drugs, supplies, equipment or other in-kind support), Clinical Condition: Opioid Use Disorder

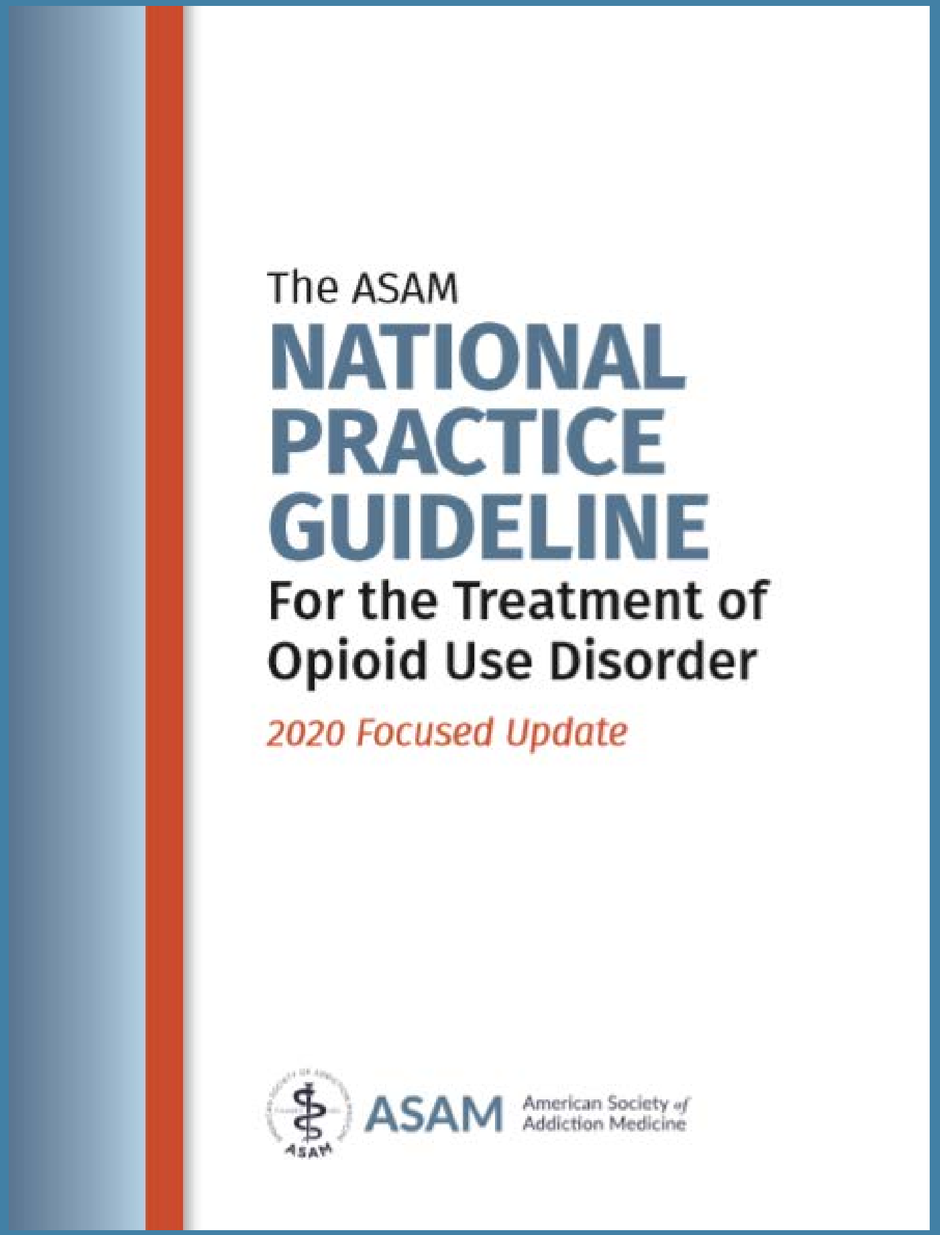
PRESENTER

Brian Hurley, MD, MBA, FASAM

- Director of Addiction Medicine for Los Angeles County’s Department of Health Services
- Clinical Director for the Treating Addiction in the Primary Care Safety Net Program funded by the California Health Care Foundation; Co-PI on a Tobacco-Related Disease Research Program-funded project integrating smoking cessation services into community mental health centers and patient-centered medical homes.
- President-Elect of the American Society of Addiction Medicine, and member of AMNet Steering Committee

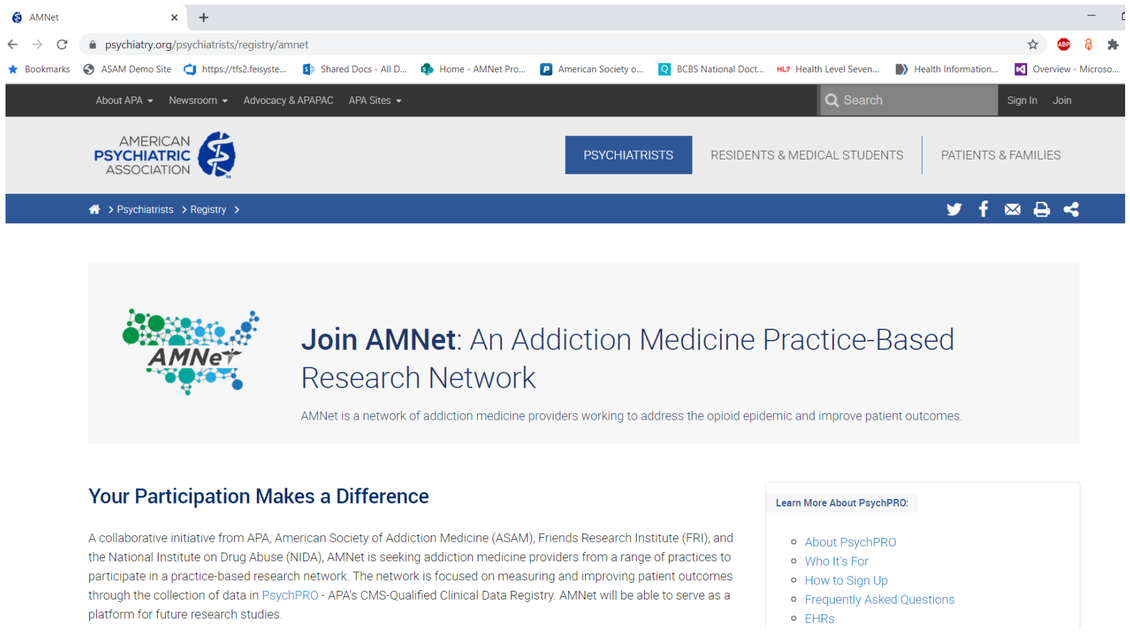
FINANCIAL DISCLOSURES – Dr. Hurley

No relevant financial disclosures



Using AMNet to Track Opioid Use Disorder Treatment Outcomes

psychiatry.org/amnet



LEARNING OBJECTIVES

At the end of the webinar, you will be able to:

- Summarize the guideline's **new and updated treatment recommendations** and discuss how they should be used in practice
- **Improve clinical care** to address remaining gaps in the treatment of OUD
- **Apply AMNet measures** to track implementation of the guideline and provide measurement-based care.

PART 1:
ASSESSMENT AND DIAGNOSIS OF OPIOID USE DISORDER

NEW AND MAJOR REVISIONS

NEW RECOMMENDATION

Comprehensive assessment of the patient is critical for treatment planning. However, completion of all assessments **should not delay or preclude** initiating pharmacotherapy for opioid use disorder. If not completed before initiating treatment, assessments should be completed soon thereafter.

Rationale:

- Since patients with opioid use disorder are at risk for significant harm – including overdose and overdose death – a delay in completion of each assessment should not delay treatment.
- This is important for enabling low-threshold treatment initiation in acute care settings.

APPLYING AMNet

Baseline Measures

1. **T**obacco, **A**lcohol, **P**rescription medication, and other **S**ubstance use Tool (TAPS-1 and 2)
2. **PhenX** Cigarette Smoking Status/Injection Drug Use
3. **B**rief **A**ddiction **M**onitor (BAM)
4. **S**hort **O**piate **W**ithdrawal **S**cale (SOWS)
5. **C**linical **O**piate **W**ithdrawal **S**cale (COWS)
6. **V**isual **A**nalog **S**cale (VAS)
7. **P**atient **H**ealth **Q**uestionnaire (PHQ-2+1)
8. **T**reatment **E**ffectiveness **A**ssessment (TEA)

PART 2:
TREATMENT OPTIONS

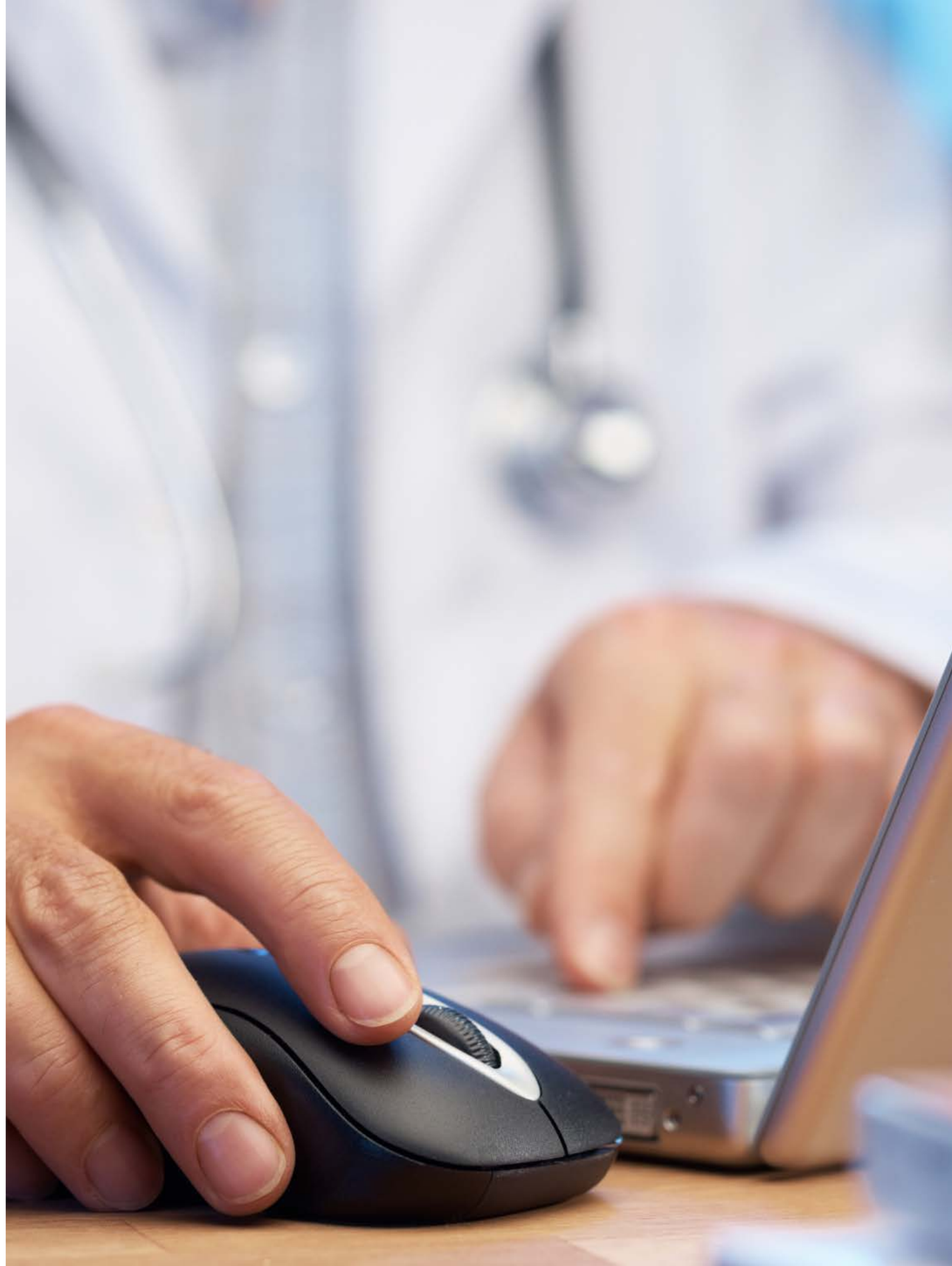
NEW AND MAJOR REVISIONS

MAJOR REVISION

- **All FDA approved medications** for the treatment of opioid use disorder **should be available to all patients**.
- Clinicians should consider the patient's:
  - preferences
  - past treatment history
  - current state of illness
  - treatment setting when deciding between the use of methadone, buprenorphine, and naltrexone.

Rationale:

- Several factors should be considered in deciding what treatment(s) to choose for a given patient.
- The choice among all FDA approved treatment options should be a shared decision between the clinician and the patient.

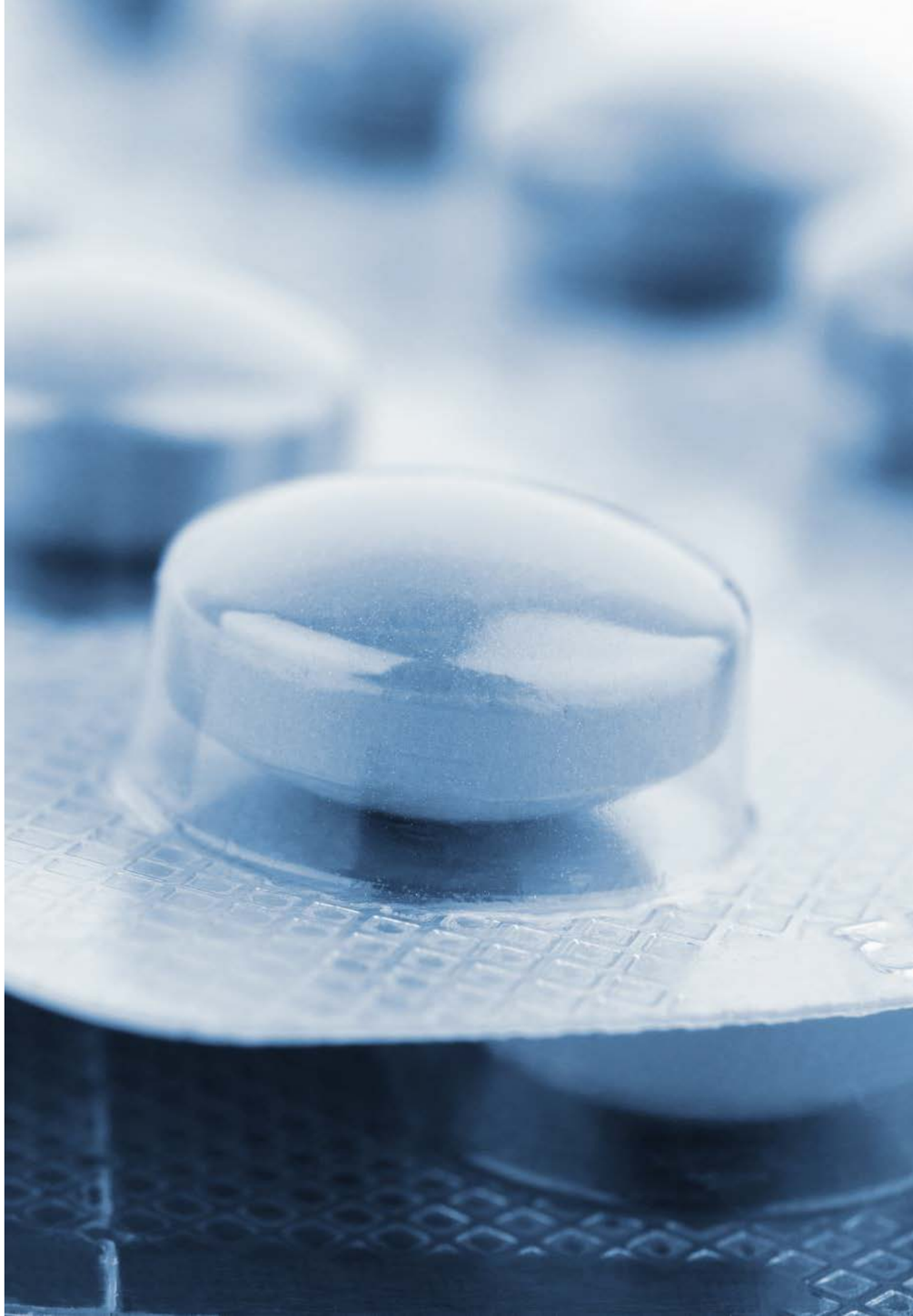


NEW AND MAJOR REVISIONS

NEW RECOMMENDATION

Opioid dosing guidelines developed for chronic pain, expressed in morphine milligram equivalents (MME), **are not applicable** to medications for the treatment of opioid use disorders.

Rationale:
Higher MME dosage of medications used in the treatment of opioid use disorder are necessary and clinically indicated for effective treatment.



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AMERICAN PSYCHIATRIC ASSOCIATION

PsychPRO
Psychiatric Patient Registry Online

2020 Dashboard

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PRO > Clinician Portal

Welcome | Practice Lists | Suicide Safety Plan

View Score

PROMIS-PAIN

PLEASE CHOOSE ONE OPTION PER QUESTION.

In the past SEVEN DAYS

How intense was his/her pain at its worst?	(✓) Had no pain	( ) Mild	( ) Moderate
	( ) Severe	( ) Very severe	
How intense was his/her average pain?	(✓) Had no pain	( ) Mild	( ) Moderate
	( ) Severe	( ) Very severe	
What is his/her level of pain right now?	(✓) No pain	( ) Mild	( ) Moderate
	( ) Severe	( ) Very severe	

PART 3:
TREATING OPIOID WITHDRAWAL

NEW AND MAJOR REVISIONS

MAJOR REVISION

Alpha-2 adrenergic agonists (e.g., FDA-approved lofexidine and off-label clonidine) are safe and effective for management of opioid withdrawal,

⬇

However, methadone and buprenorphine are more effective in reducing the symptoms of opioid withdrawal, in retaining patients in withdrawal management, and in supporting the completion of withdrawal management.

NEW AND MAJOR REVISIONS

MAJOR REVISION

Opioid withdrawal management with buprenorphine **should not be initiated until there are objective signs of opioid withdrawal**.

Rationale:
To avoid precipitated withdrawal.

Once signs of withdrawal have been objectively confirmed, a dose of buprenorphine sufficient to suppress withdrawal symptoms is given (an initial dose of 2–4mg titrated up as needed to suppress withdrawal symptoms).

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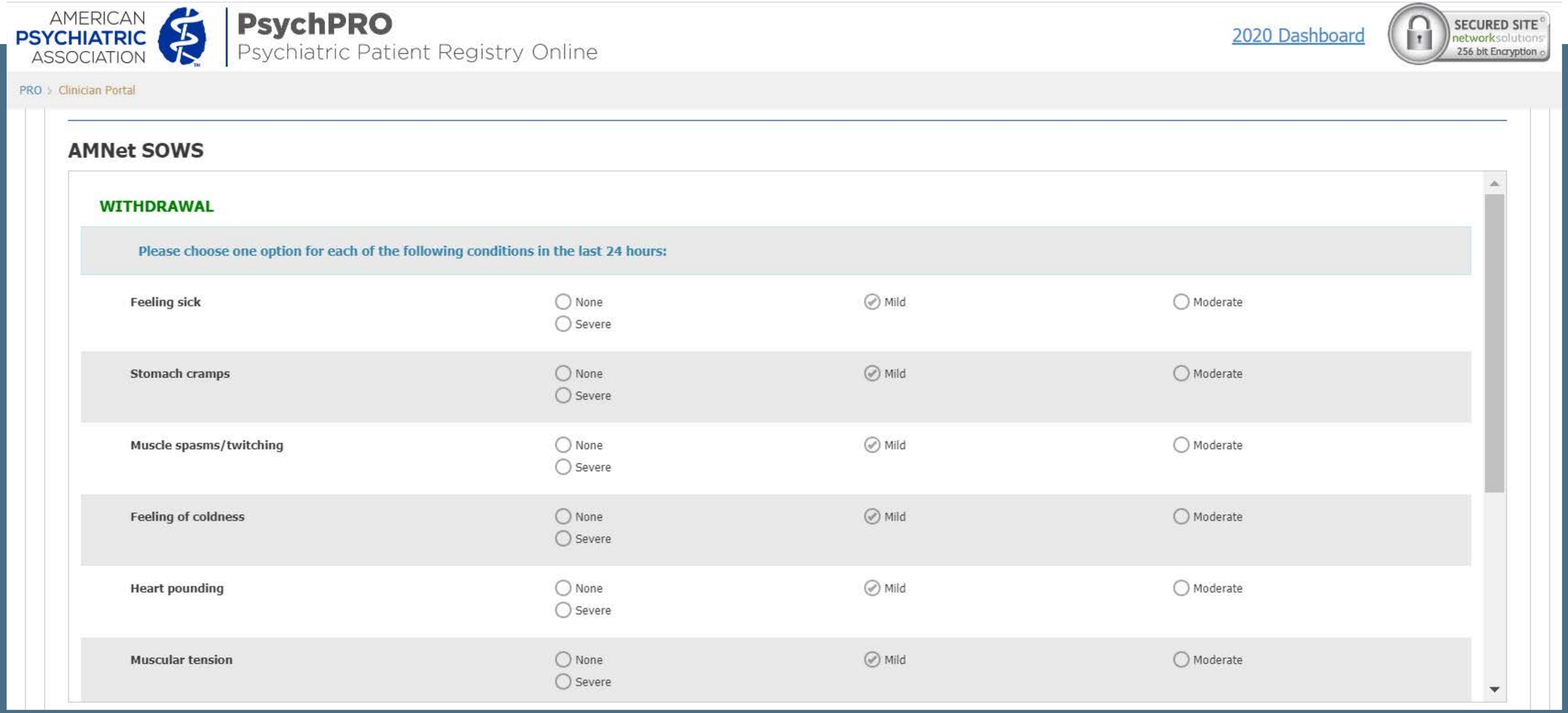
Opioid withdrawal measures: SOWS



Opioid withdrawal measures: COWS

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PRO › Clinician Portal

AMNet COWS *

WITHDRAWAL PLEASE SELECT THE OPTION THAT BEST DESCRIBES THE PATIENT'S SIGNS OR SYMPTOMS. RATE ON JUST THE APPARENT RELATIONSHIP TO OPIATE WITHDRAWAL.

Resting Pulse Rate: measured in beats/minute after the patient is sitting or lying for one minute.	○ pulse rate 80 or below ○ pulse rate greater than 120	○ pulse rate 81-100	○ pulse rate 101-120
Sweating: over past ½ hour not accounted for by room temperature or patient activity	○ no report of chills or flushing ○ beads of sweat on brow or face	○ subjective report of chills or flushing ○ sweat streaming off face	○ flushed or observable moistness on face
Restlessness: observation during assessment	○ able to sit still ○ pupils so dilated that only the rim of the iris is visible	○ reports difficulty sitting still, but is able to do so	○ frequent shifting or extraneous movements of legs/arms
Pupil size	○ pupils pinned or normal size for room light ○ pupils so dilated that only the rim of the iris is visible	○ pupils possibly larger than normal for room light	○ pupils moderately dilated
Bone or joint aches: if patient was having pain previously, only the additional component attributed to opiates withdrawal is scored	○ not present ○ patient is rubbing joints or muscles and is unable to sit still because of discomfort	○ mild diffuse discomfort	○ patient reports severe diffuse aching of joints/muscles

PART 4:
METHADONE

NEW AND MAJOR REVISIONS

MAJOR REVISION

The recommended initial dose of methadone ranges from 10 to 30 mg, with reassessment as clinically indicated (typically in 2 to 4 hours). **Use a lower-than-usual initial dose (2.5 to 10 mg) in individuals with no or low opioid tolerance.**

Rationale:
Initial dosing of methadone depends on the level of physical dependence.

NEW AND MAJOR REVISIONS

MAJOR REVISION

Following initial withdrawal stabilization, **the usual daily dose of methadone ranges from 60 to 120 mg**. Typically, methadone can be increased by **no more than 10 mg approximately every 5 days** based on the patient's symptoms of opioid withdrawal or sedation.

Some patients may respond to lower doses and some may need higher doses.

Methadone titration should be individualized based on careful assessment of the patient's response.

Long half-life of methadone contributes to overdose risk of titrated too rapidly. Revision provides more flexibility on rate of titration within appropriate range.

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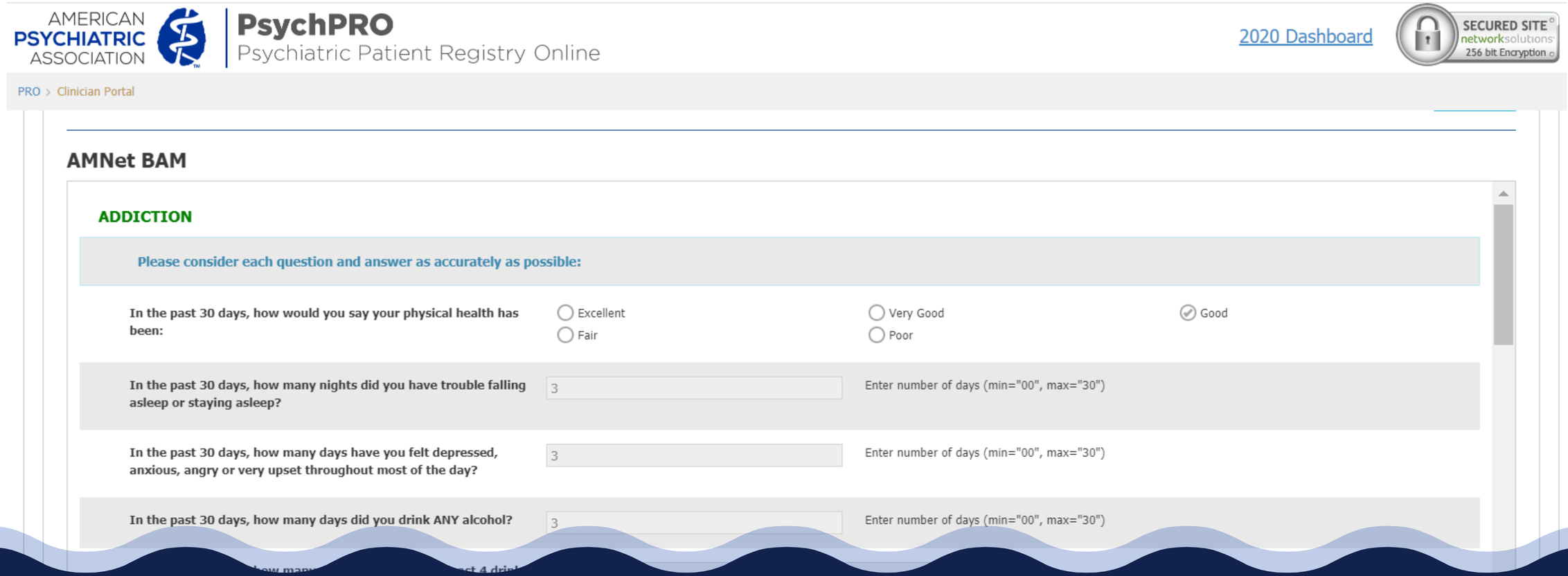


Recency and Frequency of Use

PART 5:
BUPRENORPHINE

NEW AND MAJOR REVISIONS

MAJOR REVISION

- Once **objective signs of withdrawal are observed**, initiation of buprenorphine should start with a dose of 2 to 4 mg.
- Dosages may be increased in increments of 2 to 8 mg.

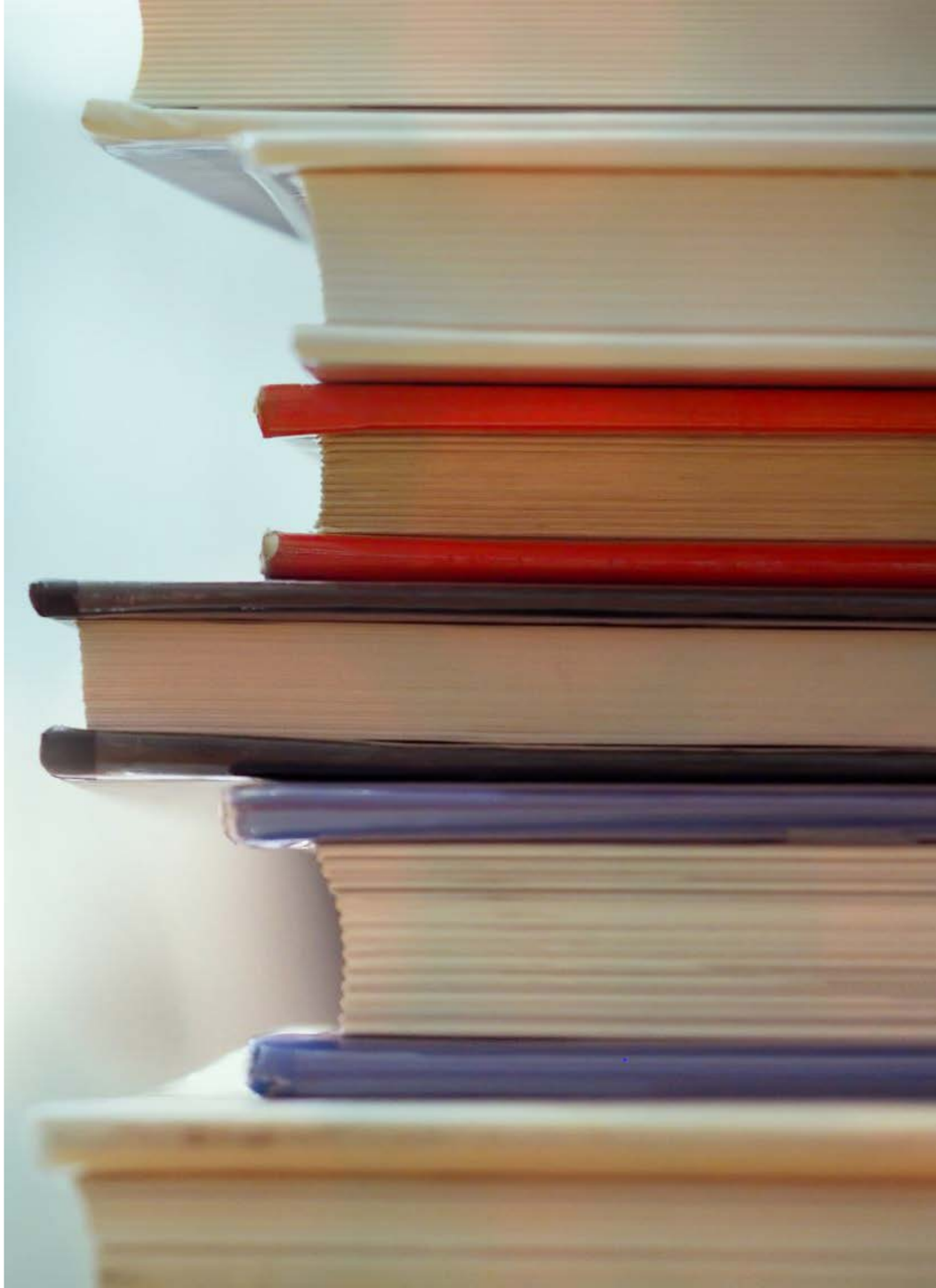
Rationale:
To avoid precipitated withdrawal, objective signs of withdrawal are important

NEW AND MAJOR REVISIONS

MAJOR REVISION

- Following initiation, buprenorphine dose should be titrated to alleviate symptoms. **Evidence suggests that 16mg per day or more may be more effective than lower doses**.

- There is limited evidence regarding the relative efficacy of doses higher than 24mg per day, and the use of higher doses may increase the risk of diversion.



NEW AND MAJOR REVISIONS

MAJOR REVISION

- Both office-based and **home-based initiation of buprenorphine** are **considered safe and effective** when starting buprenorphine treatment.

- Consider the patient's past experience with buprenorphine and assessment of their ability to manage initiation at home.

Rationale:
Home-based buprenorphine initiation has become increasingly common in recent years and is considered. safe and effective under appropriate circumstances

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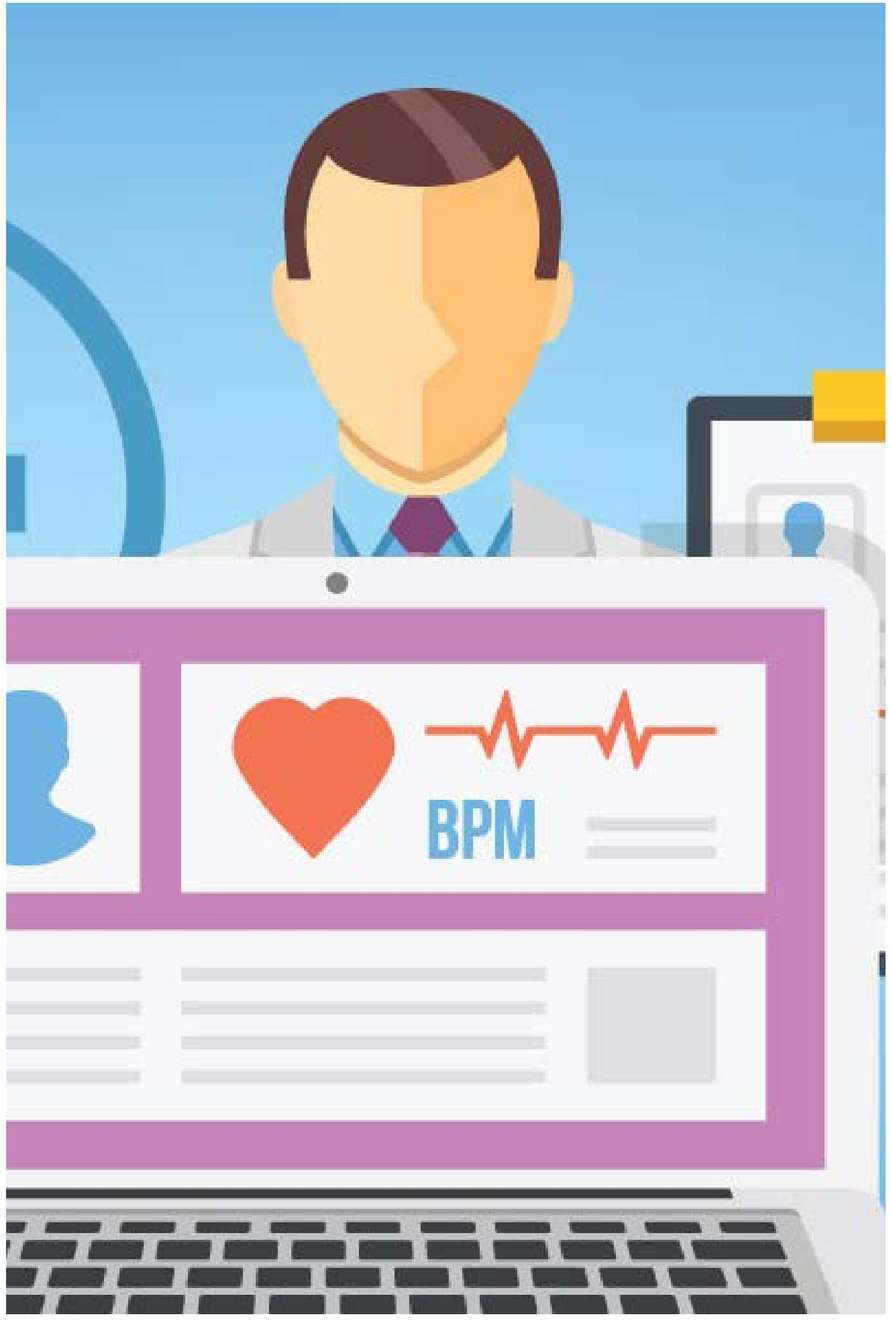

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AMNet SOWS

WITHDRAWAL

Please choose one option for each of the following conditions in the last 24 hours:

Feeling sick	○ None ○ Severe	☑ Mild	○ Moderate
Stomach cramps	○ None ○ Severe	☑ Mild	○ Moderate
Muscle spasms/twitching	○ None ○ Severe	☑ Mild	○ Moderate
Feeling of coldness	○ None ○ Severe	☑ Mild	○ Moderate
Heart pounding	○ None ○ Severe	☑ Mild	○ Moderate

Home Initiation of Buprenorphine/Naloxone: Patient Portal

PART 6:
NALTREXONE

NEW AND MAJOR REVISIONS

MAJOR REVISION

Extended-release injectable naltrexone is a recommended treatment for preventing relapse to opioid use disorder in patients who are:

- no longer physically dependent on opioids
- able to give informed consent,
- and have no contraindications for this treatment.

Rationale:

- XTR-Naltrexone has been shown to prevent relapse to opioid use disorder.
- While not eliminating, extended-release naltrexone reduces the poor adherence observed with the oral formulation

NEW AND MAJOR REVISIONS

MAJOR REVISION

Extended-release injectable naltrexone should generally be administered every 4 weeks by deep IM injection in the gluteal muscle at the set dosage of 380 mg per injection.

Some patients, including those who metabolize naltrexone more rapidly, may benefit from dosing as frequently as every 3 weeks.

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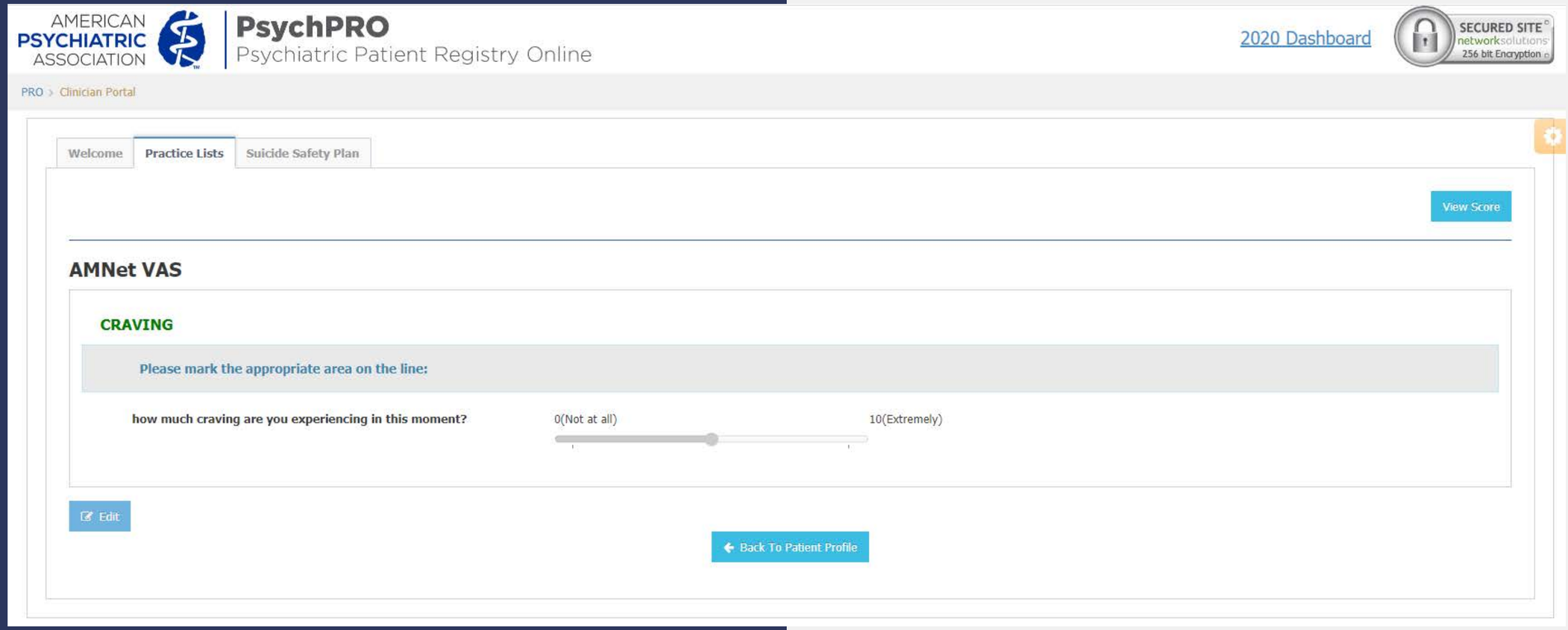
VAS (Visual Analog Scale)



PART 7:
PSYCHOSOCIAL TREATMENT IN CONJUNCTION WITH MEDICATIONS FOR THE TREATMENT OF OPIOID USE DISORDER

NEW AND MAJOR REVISIONS

MAJOR REVISION

A patient’s decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacological treatment of opioid use disorder, with appropriate medication management.

Motivational interviewing or enhancement can be used to encourage patients to engage in psychosocial treatment.

Patients should be offered or referred to psychosocial treatment, based on their individual needs.

Rationale:

- Requirements for psychosocial treatment can present barriers to access to treatment for some patients
- Research has shown that methadone and buprenorphine treatment reduce mortality even without psychosocial treatment.

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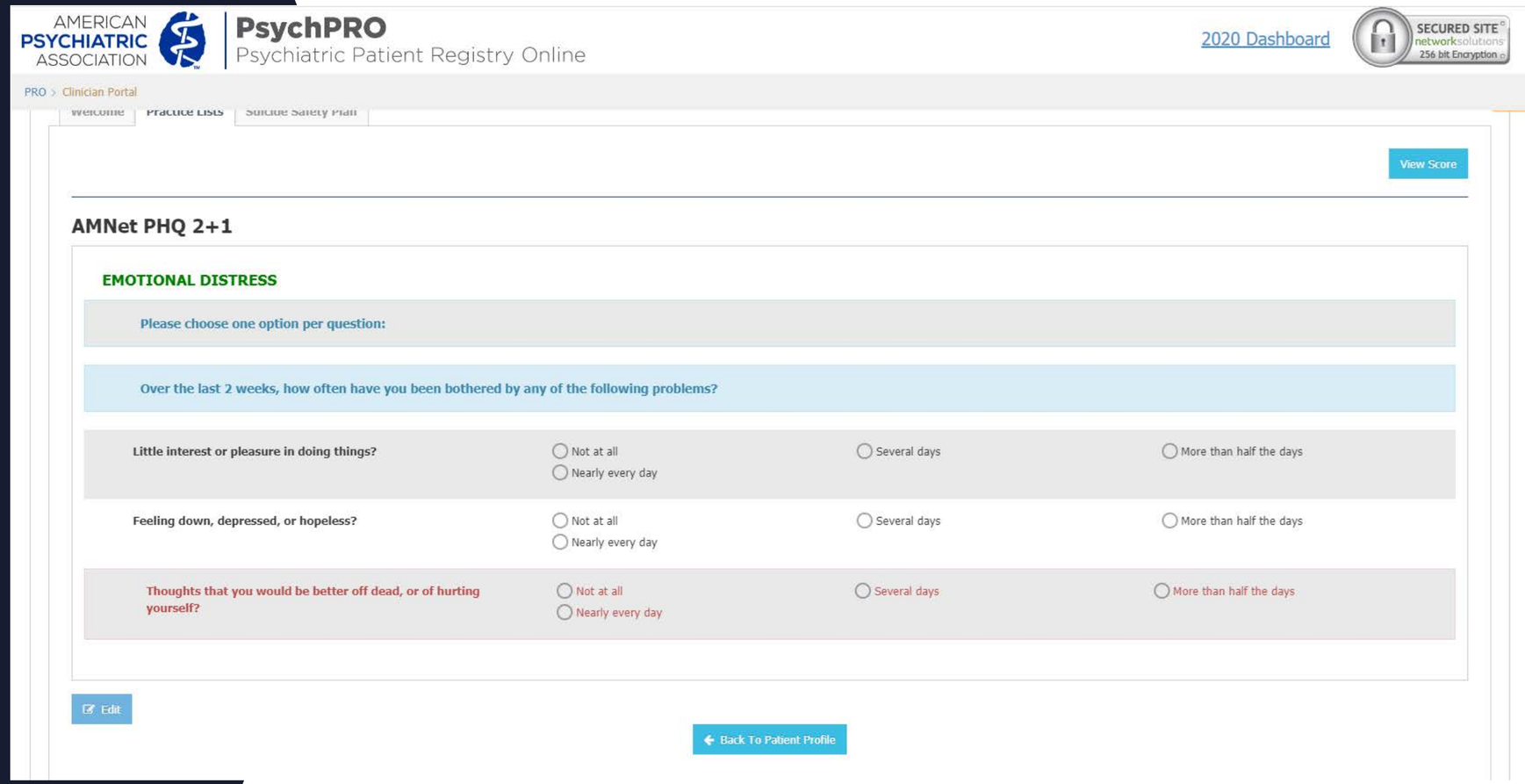
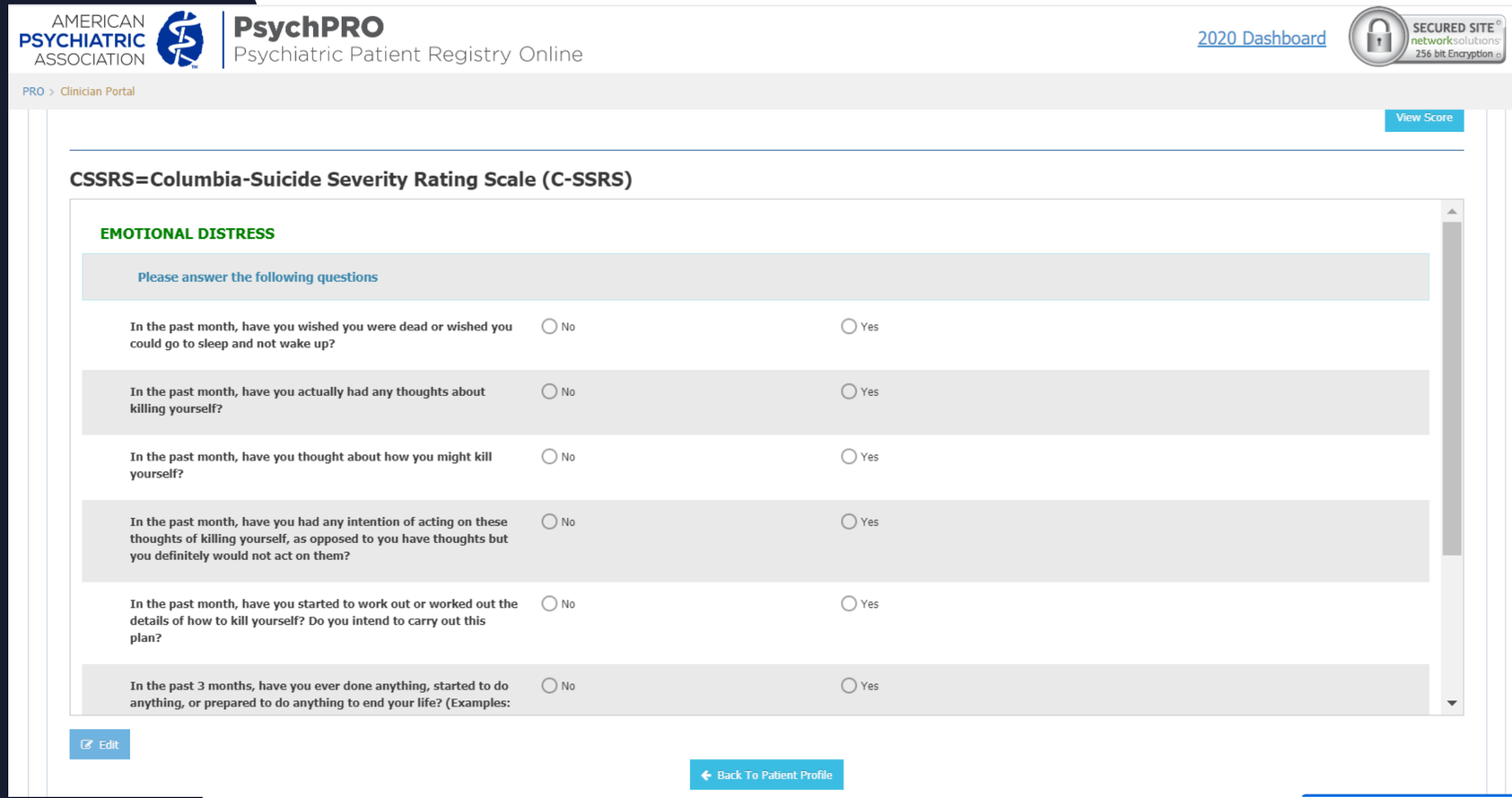
AMNet Psychosocial Instruments:

Patient Health Questionnaire



AMNet Psychosocial Instruments:

Columbia-Suicide Severity Rating Scale



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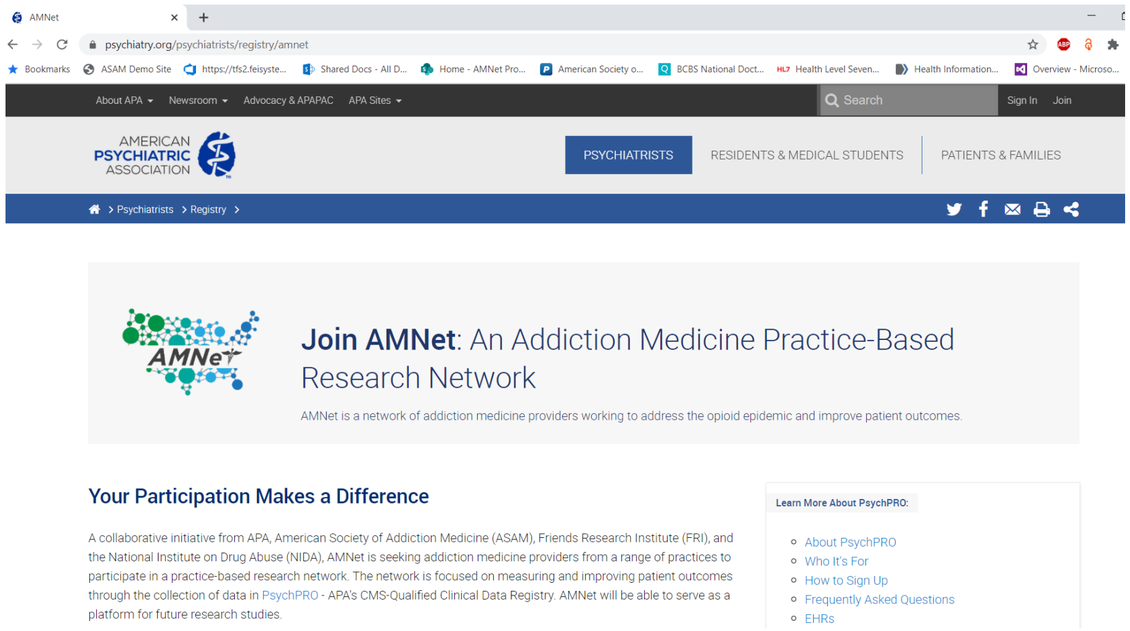

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THANK YOU.

QUESTIONS?
Email: education@asam.org **or**
Call: **301.656.3920**